Tyler Junior College
Disability Services Office

Request for Housing Accommodations

This page to be filled out by the student seeking the accommodation.

Name _____ A# _____

I am requesting the following HOUSING accommodation(s):

1): _____

2):_____

3):_____

I authorize Tyler Junior College Student Disability Services to receive documentation and speak to my current, licensed clinical professional or health care provider,

_____
Print Name of Medical Provider

Student signature: _____Date: _____

Information for Students seeking accommodations and medical providers:
Student Disability Services at Tyler Junior College complies with all federal and state disability laws to ensure equal access for qualifying persons with a disability to educational programs, services, and activities.

Please complete this form to assist Student Disability Services in determining appropriate and reasonable disability accommodations. To be considered for a housing accommodation due to a disability, Tyler Junior College requires documentation of the student's current condition from a treating licensed clinical professional or health care provider. This provider must be thoroughly familiar with the student's condition and functional limitations and must make a direct connection to the requested accommodation based on the student's current functional limitations. This provider may not be a relative of the student, and the provider must be licensed within the student's home state or state of permanent residence where the student was diagnosed/treated. Please complete this form in total. Additional paperwork may be attached if the space provided is inadequate.

All documentation submitted to the student Disability Services is considered confidential. Student Disability Services may share minimal information with appropriate College staff in order to process the request.

Please return this form to: Tyler Junior College Student Disability Services
Potter 105/PO Box 9020, Tyler, TX 75711-9020 T:903-510-2878 F:903-510-3056

This page to be filled out by the student's primary health care provider.

Print Name and Title: _____

Credentials: _____ Specialty: _____

State of License: _____ License #: _____

Address: _____

Phone: _____ Email: _____

I certify that I conducted or formally supervised and co-signed the diagnostic assessment of this student.

Signature: _____ Date: _____

1. Date of Initial Contact with Student: _____/_____ /_____.

2. *Specific Diagnosis/Disability*: Please list all relevant diagnoses, including DSM-IV or ICD Diagnoses **(text and code),** and Date of Diagnosis: _____/_____ /_____.

_____

_____

3. Procedure/assessment used to diagnose this condition: (Attach copies of results if needed)

_____

4. Current Severity of Symptoms *and* Prognosis of Condition/Disorder:

□ mild	□ good
□ moderate	□ fair
□ severe	□ poor

5. Date of last office visit with Student: _____/_____ /_____

6. Prescribed treatment or medications:

_____

_____

7. Describe symptoms related to the student's condition that cause significant impairment in a major life activity. Include how this limitation affects the student's ability to participate in student life.

_____

_____

8. State specific recommendations regarding housing, and rationale based upon the student's condition. Indicate why/how the recommended change(s) to the environment are necessary. Recommendations must be clearly linked to functional limitations of the student's condition.

_____

_____

Thank you for completing this document. Return information below. All documentation submitted is considered confidential

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